

# CHRONIC DISEASE RISK REDUCTION SFY2020 REQUEST FOR PROPOSAL

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## Background

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The mission of the Chronic Disease Risk Reduction community grant program is to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity, and nutrition, while addressing health equity. Chronic diseases account for 90 percent of health care costs each year.<sup>1</sup> Based on national estimates in 2014, more than \$22 billion was spent in Kansas on chronic disease.<sup>2</sup> As states struggle to meet the staggering costs of health care, the most cost-effective interventions are frequently overlooked. Impressive achievements in population health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury and by helping people actively manage their chronic conditions.

## Social Determinants of Health

Social determinants of health are conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes.<sup>3</sup> Social determinants of health are, in part, responsible for the unequal and avoidable differences in health status with and between communities.<sup>4</sup> Many chronic conditions are more common, diagnosed later, and result in worse outcomes for particular individuals. Well-known factors include low socioeconomic status, low educational status, and inadequate access to (or utilization of) quality health care. There are other adverse determinants of health as well. Examples include residence in geographic areas that have poor environmental conditions (e.g., violence, poor air quality, and inadequate access to healthy foods), racism, inadequate personal support systems, limited literacy, and limited English proficiency (LEP). These determinants are often associated with racial and ethnic minority and underserved communities, and are among the determinants of health.<sup>5</sup>

While health disparities can be addressed at multiple levels, the Chronic Disease Risk Reduction Program focuses on policy, systems, and environmental strategies designed to address health equity and improve the social determinants of health. Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.<sup>5</sup>

**Throughout the work plan strategies, Chronic Disease Risk Reduction applicants are required to describe how proposed work plan interventions will address health equity in their community to improve the health of all Kansans.**

## Health Disparities Around Tobacco Use and Obesity

**Tobacco Use** - Tobacco use is the leading cause of preventable death and disease in Kansas. Annually, cigarette use alone causes approximately 4,400 deaths in Kansas, costing more than \$1.12 billion in medical expenditures and \$1.09 billion in lost productivity.<sup>6</sup> The prevalence of current cigarette smoking among adults age 18 and older declined significantly in Kansas from 20.0 percent (95% CI: 19.3% - 20.7%) in 2013 to 18.1 percent (95% CI: 17.2% - 18.9%) in 2014.<sup>7,8</sup> The prevalence of current smoking did not change significantly from 2014 to 2017.<sup>9</sup> Despite overall declines in cigarette smoking, some population groups have disproportionately higher rates of smoking. For example, about three in ten adults with an annual household income of less than \$15,000 smoke compared to about one in ten adults with an annual household income of \$50,000 or more.<sup>9</sup> The percentage of Kansas adults who currently smoke is significantly higher among males

compared to females, Black or African American and multi-racial adults compared to White adults, younger adults compared to those 65 years and older, and those living with a disability or with poor mental health. Adults who rent their home also have a significantly higher prevalence than adults who own their home.<sup>9</sup> Adults residing in multi-unit housing have a significantly higher prevalence of current smoking compared to adults residing in single family homes.<sup>9</sup> The 2017 KS BRFSS also found that 10.1 percent (95% CI: 9.4% - 10.9%) of adult males in Kansas use smokeless tobacco and 4.6 percent (95% CI: 4.2% - 5.0%) of adults currently use electronic cigarettes (e-cigarettes).<sup>9</sup> The percentage of Kansas adults who currently use e-cigarettes is significantly higher among males, younger adults, those with lower annual household income of less than \$15,000 compared to those with an annual household income, and those living with a disability or with poor mental health.

Despite the substantial disparities, 57.1 percent (95% CI: 54.9% - 59.2%) of current smokers in Kansas tried to quit smoking in the past year and members of sub-populations disproportionately impacted by tobacco use are equally interested in quitting.<sup>9</sup>

Additionally, youth tobacco use remains an important issue that needs to be addressed. Data from the 2017 Kansas Youth Risk Behavior Survey (KS YRBS) reveal that 7.2 percent (95% CI: 5.6% - 9.1%) of high school students reported currently using cigarettes.<sup>10</sup> The 2017 KS YRBS also indicates that 9.1 percent (95% CI: 7.3% - 11.1%) of male high school students in Kansas currently use smokeless tobacco and 10.6 percent (95% CI: 8.7% - 12.9%) of high school students use e-cigarettes.<sup>10</sup>

The Centers for Disease Control and Prevention has resources that provide information and examples that may be useful in reducing health disparities and advancing health equity in tobacco control. [Health Equity in Tobacco Prevention and Control](#) and [A Practitioner's Guide for Advancing Health Equity](#), and [Community Strategies for Preventing Chronic Disease: Tobacco Free Living Strategies](#).

**Obesity** - Obesity, defined as a body mass index (BMI) greater than 30 kg/m<sup>2</sup>, increases the risk for several chronic diseases including coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis.<sup>11</sup> Currently, nearly one in three Kansas adults aged 18 years and older is obese (32.3 percent, 95% CI: 31.5% - 33.2%).<sup>7</sup> As with tobacco use, there are specific sub-populations in Kansas who are disproportionately impacted by obesity. The percentage of Kansas adults who are obese is significantly higher among Kansans ages 25 to 64 years compared to those aged 18 – 24 years and those age 65 years and older, Hispanic adults, persons with lower annual household incomes, and those living with a disability or with poor mental health status. In 2017, 28.4 percent of Kansas high school students were overweight or obese (15.3% overweight, 95% CI: 13.4% - 17.3%; 13.1% obese, 95% CI: 11.3% - 15.0%).<sup>10</sup>

**Physical Activity** - Regular physical activity is associated with reduced risk of several chronic health conditions including coronary heart disease, stroke, type 2 diabetes and certain cancers.<sup>12</sup> Participating in physical activity also delays the onset of functional limitations,<sup>13</sup> prevents obesity<sup>11</sup> and is essential for normal joint health.<sup>14</sup> The U.S. Department of Health and Human Services' *2008 Physical Activity Guidelines for Americans* recommends that adults participate in at least 150 minutes a week of moderate-intensity aerobic activity, or 75 minutes a week of vigorous-intensity aerobic activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. The *Guidelines* also recommend that children and adolescents participate in at least 60 minutes of physical activity per day.

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In 2017, 81.0 percent (95% CI: 80.3% - 81.7%) of Kansas adults aged 18 years and older did not meet these physical activity guidelines and 27.9 percent (95% CI: 27.1% - 28.7%) of Kansas adults did not participate in any physical activity other than their regular job during the past month.<sup>7</sup> The percentage of Kansas adults that did not participate in any physical activity other than their regular job is significantly higher among older adults, those with lower income, and those living with a disability or with poor mental health. In 2017, only 26.5 percent (95% CI: 23.3% - 30.0%) of Kansas high school students engaged in recommended levels of physical activity (i.e., at least 60 minutes per day).<sup>15</sup>

**Nutrition** - Research shows that eating at least two and a half cups of fruits and vegetables per day is associated with a reduced risk of many chronic diseases, including cardiovascular disease and hypertension. A diet rich in fruits and vegetables can also help adults and children achieve and maintain a healthy weight.<sup>16</sup> In 2017, about one in six Kansas adults age 18 years and older (17.3%, 95% CI: 16.6% - 18.0%) consumed vegetables less than 1 time per day.<sup>i</sup> The percentage of Kansas adults who consumed vegetables less than 1 time per day was significantly higher among males, adults age 18-24 years, African American adults, Hispanic adults, and those with lower annual household income, living with a disability or with poor mental health.<sup>9</sup> In 2017, about two in five (37.5%, 95% CI: 36.7% - 38.4%) of Kansas adults consumed fruit less than 1 time per day.<sup>9</sup> Some sub-populations with significantly lower fruit consumption are similar to those noted for vegetable consumption. The percentage of adults who did not consume fruit at least once per day is significantly higher among males, adults age 18 to 24 years, and among those with lower annual household incomes, living with a disability or with poor mental health status. In 2017, only 12.5 percent (95% CI: 11.0% - 14.2%) of Kansas high school students ate fruit or drank 100% fruit juice three or more times per day and only 9.1 percent (95% CI: 7.9% - 10.4%) ate vegetables three or more times per day.<sup>15</sup>

**Chronic Disease Self-Management Education:** Chronic Disease Self-Management Education (CDSME) programs are evidence-based classes with curriculum developed by Stanford University to improve the quality of life of those living with chronic disease.<sup>ii</sup> The program specifically addresses arthritis, diabetes and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshop participation is recommended for anyone living with one or more chronic conditions, family and friends of those living with a chronic condition and caregivers. These interactive workshops provide participants with techniques to deal with problems associated with chronic disease, nutrition, appropriate exercise, appropriate use of medications, communicating effectively with family, friends and health professionals and how to evaluate new treatments. Participants also learn and practice problem-solving and action planning.

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<sup>i</sup> Beginning in 2017, vegetable consumption is computed by the following questions: 1) "How often did you eat a green leafy or lettuce salad, with or without other vegetables?", 2) "How often did you eat any kind of fried potatoes, including French fries, home fries, or hash browns?", 3) "How often did you eat any other kind of potatoes, or sweet potatoes, such as baked, boiled, mashed potatoes, or potato salad?", and 4) "Not including lettuce salads and potatoes, how often did you eat other vegetables?"

<sup>ii</sup> <http://patienteducation.stanford.edu/programs/cdsmp.html>

## Chronic Disease Risk Reduction (CDRR) Grant Request for Proposal

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The purpose of this grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies and best practices that impact tobacco use, physical activity, nutrition, and chronic disease self-management.

All applications must address tobacco, while work in physical activity, nutrition, and CDSME is optional. This document provides background and guidelines for developing a full proposal and submission instructions. This is a competitive grant process. Grants will be awarded based upon the quality and clarity of the proposed activities and achievability of proposed outcomes. Please follow the directions carefully. The grant program is structured to promote community program progress in two distinct phases:

1. **Planning and Capacity (1 year maximum):** This phase is appropriate for applicants who lack a functioning chronic disease control coalition. Planning applicants should **not** select interventions.

### Planning and Capacity Phase Deliverables:

- Functional chronic disease prevention coalition. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies.
- Attend the annual Community Health Promotion Summit, two other CDRR approved trainings and three CDRR regional grantee meetings.
- Community chronic disease prevention plan based on community data available from existing sources.

### Timeline and Staffing:

- Maximum of one year
- 0.25 FTE minimum (a minimum of 10 hours per week)
- 25 percent local match

2. **Implementation:** This is appropriate for applicants with a functioning coalition. Grant funds support local tobacco control, physical activity, nutrition, and chronic disease self-management programming.

### Implementation Phase Deliverables:

- Tobacco use and prevention activities
- Functional chronic disease prevention coalition that meets at least quarterly. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies outlined in the work plans.
- Attend the annual Community Health Promotion Summit, two other CDRR approved trainings and three CDRR regional grantee meetings.

### Timeline and Staffing:

- 0.25 FTE minimum (a minimum of 10 hours per week)
  - 25 percent local match
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**GRANTEE REQUIREMENTS (if awarded):****Administration and Management**

<b>Requirement</b>	<b>Implementation</b>	<b>Planning</b>
1. Participate in CDRR technical assistance and professional development opportunities.	yes	yes
2. Host one mid-year Community Health Specialist site visit by December 30 and participate in bi-monthly progress calls.	yes	yes
3. Report progress at the workplan level at least 5 days prior to bi-monthly calls and site visits and at mid-year (due Jan. 15) and year-end (due July 15). Where applicable, progress should include a description of how underserved populations are engaged and reached.	yes	yes
4. Submit all communications items to Community Health Specialist for review at least two weeks prior to date needed.	yes	yes
5. Consult KDHE epidemiologist to identify appropriate methods for addressing any perceived data gaps. This consult should be initiated during the initial brainstorming phase.	yes	yes
6. Report performance measures at mid-term and final.	yes	no

**Data and Information Activities**

<b>Requirement</b>	<b>Implementation</b>	<b>Planning</b>
1. Leverage data available from existing sources to determine community's needs and justify selected workplans.	yes	yes
2. Recruit schools and administer youth surveillance as requested (i.e., Youth Risk Behavior Survey).	yes	yes
3. Collect and submit local policies as passed.	yes	yes
4. For communities awarded CDSME funding, document workshops, potential program delivery partners and referring providers or organizations as instructed.	yes	no

**Interventions to Improve Public Health Activities**

<b>Requirement</b>	<b>Implementation</b>	<b>Planning</b>
1. Must select at least one workplan under the goal area Preventing Youth Initiation of Tobacco Use Among Young People or Eliminating Nonsmoker's Exposure to Secondhand Smoke.	yes	no
2. Must engage youth in activities in the goal area Preventing Youth Initiation of Tobacco Use Among Young People.	yes	no, but we recommend connecting with schools and youth leaders, and promoting Resist.

**Communications and Promotion Activities**

<b>Requirement</b>	<b>Implementation</b>	<b>Planning</b>
1. Integrate Kansas Tobacco Quitline and Brief Tobacco Intervention promotion into tobacco control activities.	yes	no
2. If you perform paid media activities (advertisements in newspapers, billboards or paid content on social media), input the information into the required reporting system.	yes	no
3. Capitalize on local interventions, national reports/data releases and current events to generate at least four instances of earned media. Record into the required reporting system.	yes	not required, but recommended
4. Capitalize on local interventions, national reports/data releases and current events to generate at least three social media posts <b>per month</b> . Use the hashtags <b>#kdhecdrr</b> and <b>#healthyKS</b> with each social media post related to CDRR workplans. Record into the required reporting system.	yes	not required, but recommended
5. Perform at least two public relations efforts geared toward policy/decision makers and focused on priority policy issues. Record into the required reporting system.	yes	no
6. Complete one success story per approved program area per year: one for tobacco, one for PAN, and one for CDSME. Use the Success Story form.	yes	no

**Partnership Activities**

<b>Requirement</b>	<b>Implementation</b>	<b>Planning</b>
1. Create and/or maintain a diverse chronic disease prevention/health promotion coalition with membership comprised of youth, parents, businesses, media, schools, religious or fraternal organizations, civic or volunteer groups, health care professionals, government agencies, and other individuals/organizations interested in chronic disease prevention/health promotion. The coalition should also include adequate representation from targeted priority populations, and meet at least quarterly.	yes	yes
2. Create and/or maintain a community coalition or a subcommittee of a larger community health coalition that focuses on <b><u>tobacco strategies</u></b> and that meets at least quarterly.	yes	yes
3. Complete a CDRR Coalition Assessment every three years or per your Community Health Specialist recommendation to improve coalition planning and function.	yes	no

### Eligibility

Eligible applicants are local health departments, which are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

### Match

All applicants must provide a minimum of 25 percent match for every dollar awarded. The 25 percent match may be in cash, in-kind or a combination of both from county and/or public and private sources. Sources of in-kind match may include grants that compliment tobacco prevention, physical activity, nutrition, and chronic disease self-management. Local funds that support existing evidence-based cessation program services and local funds provided for enforcement activities may also serve as local match. Please consult your Community Health Specialist for assistance in determining the source or amount of cash match required for a specific program. The applicant must document all costs used to satisfy the matching requirements. Program resources may be used for consultants, staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts to fulfill the match requirement.

### Available Funding and Budget

Tobacco prevention funding is contingent upon appropriations by the Kansas State Legislature. Physical activity and nutrition funding and CDSME funding are contingent upon availability of funds. Awards are competitive and requests typically exceed available funds.

The budget should be entered using the Kansas Grant Management System (KGMS) with detailed budget item descriptions. Describe each staff member's role and responsibilities. The CDRR form "Salary Worksheet" should be completed and uploaded into KGMS. The "Salary Worksheet" is available for download within KGMS.

Grant funds may be used for reasonable costs associated with the program's activities including:

- ✓ salary
- ✓ travel
- ✓ registration fees
- ✓ supplies
- ✓ advertising, signage (requires prior approval from the Communication Coordinator to ensure statewide coordination)
- ✓ consultation
- ✓ facility rental
- ✓ equipment rental
- ✓ speakers/presenters
- ✓ educational materials

Grant funds may **NOT** be used to:

- ✗ provide meals or snacks
  - ✗ provide direct services, individual or group cessation services
  - ✗ provide direct patient care or rehabilitation
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- ✕ provide personal health services medications (NRT)
- ✕ supplant existing funding from Federal, State, or private sources
- ✕ directly enforce policies
- ✕ pay for an internship
- ✕ provide incentives and promotional items
- ✕ sustained classroom instruction or purchase curriculum
- ✕ lobby government entities, or defray other costs associated with the treatment of diseases
- ✕ purchase capital equipment

Communities are encouraged to get partner contributions for food, which may be used as matching funds.

### Review Procedures

Applications will initially be reviewed for completeness and responsiveness. Incomplete applications and applications that do not meet the eligibility criteria will not advance for further review. Applicants will be notified if their applications did not meet eligibility or published submission requirements.

Community Health Promotion staff may respond to questions regarding application processes. However, to provide an equitable and fair process to all applicants, staff will not respond to questions regarding application content. Community Health Promotion staff will not read the application prior to submission. Grant applications will be reviewed by a team of external and internal reviewers. The applicant organization's performance and compliance as a CDRR grantee during the past two fiscal years will be considered and discussed when scoring and ranking grant applications. Planning Grants will be scored separately to eliminate competition barriers for new applicants.

Funding decisions are based on application score, past performance, demonstration of need, appropriate expenses, population size, strength of plan, and applicant's ability to address health equity.

**Award Administration Information** - Chosen applicants will receive a Letter of Award and Grant Contract from the Kansas Department of Health and Environment. The first disbursement of grant funds may be expected on or before July 31, 2019. Any requested revisions to program activities, evaluation and/or budgets must be completed before the second disbursement of grant funds. Grant activities will be expected to start on July 1, 2019 and continue through June 30, 2020.

### Grant Timeline

March	April	May	June	July	August
March 15, CDRR Grant application due	Review period	Award recommendations made	Award notices sent	July 1, Grant year begins, 25% of award funds distributed	August 15, revisions due
September	October	November	December	January	February
Bi-monthly call Regional Meeting	October 1, 25% of award funds distributed	Bi-monthly call	Site Visit Regional Meeting	January 1, 12.5% of award funds distributed January 15, mid-year report with performance measure reporting and financial status report due	February 15, 12.5% of award funds distributed



March	April	May	June	July	
Bi-monthly call	April 1, final 25% of award funds distributed Regional Meeting	Bi-monthly call	June 30, Grant year ends	July 15, end of year report with performance measure reporting and financial status report due	

### Goal Areas

The following section describes the goal/content areas covered in CDRR that will have the greatest impact to prevent chronic disease, including: tobacco use prevention and dependence treatment; access to healthy foods and physical activity opportunities, including community design strategies; and chronic disease self-management education programs.

Communities are encouraged to think about the community as a whole, with synergy across strategies. Non-traditional partners should be included in the planning and implementation. Applicants should use evidence-based strategies and best practices focused on policy, systems and environmental changes.

**NOTE: To be funded for CDRR, at least one tobacco workplan under Prevention or Secondhand Smoke must be selected. The remainder of topics are optional. Grantees may select no more than 5 workplans.**

### PREVENT INITIATION OF TOBACCO USE AMONG YOUNG PEOPLE

The 2012 Surgeon General's Report shows that 99% of smokers begin smoking and using other forms of tobacco by age 26; limiting exposure and access is a key strategy to prevent tobacco use. Engagement of youth in tobacco control involves providing the opportunity for young people to gain the ability and authority to make decisions that help improve the policy environment, change social norms, and reduce smoking initiation and consumption in their communities.

Implementing comprehensive smoke-free school policies can benefit young people from all racial/ethnic and socioeconomic backgrounds equally and is a good way to target social determinants of health related to tobacco use.<sup>17</sup> Comprehensive tobacco-free policies prohibit all forms of tobacco for students, staff, and visitors in school buildings, on school grounds and in school vehicles at all times. It is also recommended that comprehensive tobacco-free school policies prohibit tobacco use at off-campus school-sponsored events, add electronic cigarettes into the definition of prohibited products and prohibit tobacco industry sponsored materials (including tobacco clothing) and sponsorship. Opportunities to support cessation can include the Kansas Tobacco Quitline and other local resources.

In the tobacco retail setting, marketing, advertising, and promotional strategies have been especially heavily marketed to low-income, minority, and young adult populations, making them a specific target of the tobacco industry and creating communities that are disproportionately susceptible to tobacco use.<sup>18</sup> Research has also shown that lower-income communities have higher amounts of tobacco advertising within 1,000 feet of schools compared to higher income communities. Higher amounts of marketing and retailers impacts the amount of experimental smoking among students.<sup>18</sup> Increasing the minimum age of sale and purchase of tobacco products to 21 years of age represents an opportunity for communities to further efforts to prevent initiation of tobacco use. A March 2015 Institute of Medicine study estimated that Tobacco 21 would reduce national smoking rates by 25% among 15-17 year olds, by 15% among 18 year olds, and by 15% among 19-20 year olds.<sup>19</sup>

**KEY RESOURCES:**

- Best Practices User Guide; Youth Engagement - State and Community Interventions: <http://stacks.cdc.gov/view/cdc/5628>
- Resist - The State Youth Tobacco Prevention Program: <http://resisttobacco.org/>
- Taking Down Tobacco - A comprehensive youth advocacy training program created by the Campaign for Tobacco-Free Kids: [www.takingdowntobacco.org](http://www.takingdowntobacco.org)
- The Toll of Tobacco in Kansas by the Campaign for Tobacco Free Kids: [http://www.tobaccofreekids.org/facts\\_issues/toll\\_us/kansas](http://www.tobaccofreekids.org/facts_issues/toll_us/kansas)
- The Truth Initiative - <https://truthinitiative.org/>
- Kick Butts Day: <https://www.kickbuttsday.org/>
- The Great American Smokeout: <https://www.cancer.org/healthy/stay-away-from-tobacco/great-american-smokeout.html>

**Tobacco Free School Resources:**

- Model Tobacco Free Policy for Kansas Schools: <http://www.publichealthlawcenter.org/sites/default/files/resources/Kansas-tobacco-free-schools-model-policies-2017.pdf>
- Americans for Nonsmoker's Rights Resources: <http://www.no-smoke.org/goingsmokefree.php?id=447>
- Tobacco-free College Campus Initiative: <http://tobaccofreecampus.org/resources>

**Retail Access Resources:**

- Counter Tobacco-Policy Solutions: <http://www.countertobacco.org/policy/>
- Counter Tobacco-Store Assessment Tools: <http://www.countertobacco.org/resources-tools/store-assessment-tools/>
- ChangeLab Solutions-Tobacco Retailer Licensing: <http://www.changelabsolutions.org/publications/tobacco-retailer-licensing>
- National Tobacco 21: [www.tobacco21.org](http://www.tobacco21.org)
- Best Practices for Youth Access Laws: <https://www.tobaccofreekids.org/assets/factsheets/0074.pdf>

**Electronic Cigarette Resources:**

- CDC's Electronic Cigarette Homepage: [https://www.cdc.gov/tobacco/basic\\_information/e-cigarettes/index.htm](https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm)
- Stanford Med's Tobacco Prevention Toolkit – E-cigs and Vape Pens: <https://med.stanford.edu/tobaccopreventiontoolkit/E-Cigs.html>
- E-cigarettes & Young People – 2017 U.S. Surgeon General: <https://e-cigarettes.surgeongeneral.gov/>

**\*Note: All prevention workplans require youth participation.**

**Prevention (1): Increase the number of youth engaged in tobacco control efforts. Must promote, recruit and train youth in the Taking Down Tobacco online training program (e.g., establishment of a youth tobacco coalition/Resist chapter, establishment of youth-adult partnerships on existing tobacco coalition, counter marketing campaigns).**

**Required Performance Measures:**

1. Number of youth who have completed the Tobacco 101 online training course (found at Taking Down Tobacco website - <http://www.takingdowntobacco.org/training-menu>).
2. Number of youth who have completed all of the Taking Down Tobacco Become a Trainer courses: Taking Down Tobacco 101, Become a Trainer, and The Core 4 (Messaging Matters, Activities that Kick Butts, Informing Decision-Makers, and Mastering the Media).

**Prevention (2): Increase the number of communities that adopt, strengthen and enforce policies that restrict youth access to tobacco products.**

**Required Performance Measures:**

1. Number of youth who participate in retail-related strategies for tobacco use prevention.
2. Number of policies passed during grant period that restrict youth access to tobacco products, including restrictions on flavored tobacco products, proximity of retailer to a school, or age of purchase.

**Prevention (3): Increase the number of schools or school districts with 100% tobacco-free policies and plan for enforcement.**

**Required Performance Measures:**

1. Number of school age youth who participate in tobacco use prevention activities.
2. Proportion of schools or school districts with comprehensive<sup>iii</sup> tobacco-free school grounds policies (provide both the total number of schools or school districts and the number of schools or school districts with comprehensive tobacco-free policies).
3. Proportion of school aged youth enrolled in a school or school district with comprehensive<sup>iii</sup> tobacco-free school grounds policies (provide both the total number of school age youth enrolled in schools or school districts and the number of students enrolled in schools or school districts with comprehensive tobacco-free policies).
4. Proportion of staff employed by schools or school districts with comprehensive tobacco-free school grounds policies (provide both the total number of staff employed by schools or school districts and the number of staff employed by schools or school districts with comprehensive tobacco-free policies).

**Prevention (4): Increase the number of colleges/universities with 100% tobacco-free policies and plan for enforcement.**

**Required Performance Measures:**

1. Number of college or university students who participate in tobacco use prevention activities.
2. Number of post-secondary institutions with 100% tobacco-free or smoke-free college campus policies.
3. Number of students protected by a 100% tobacco-free or smoke-free college campus policy.
4. Number of staff protected by a 100% tobacco-free or smoke-free college campus policy.

**ELIMINATE NONSMOKERS' EXPOSURE TO SECONDHAND SMOKE**

According to the Centers for Disease Control and Prevention (CDC), there is no risk-free level of exposure to tobacco smoke, including secondhand smoke (SHS); even brief exposure can be harmful to health. In the United States, it is estimated that one in four non-smokers are exposed to SHS, and 4 in 10 children are exposed to SHS. For black or African American children, those numbers are 7 in 10.<sup>20</sup>

Smoke-free policies can play an important role in protecting residents, especially children, from SHS and preventing fires in multi-unit housing complexes. These policies protect residents from risks of developing

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<sup>iii</sup> Comprehensive tobacco-free policy for school districts are policies that prohibit the use of all tobacco products by anyone (including students, staff and visitors) on school property or at school events at all times. School property means all property whether owned, leased, rented or otherwise used by a school and includes buildings, grounds and vehicles.

heart disease, stroke, and lung cancer in adults, and Sudden Infant Death Syndrome (SIDS), lung problems, ear infections, and asthma attacks among children and babies.<sup>20</sup>

A key component of health equity work in tobacco control is eliminating SHS exposure disparities between groups.<sup>21</sup> Comprehensive tobacco control policies that are well-enforced help to reduce tobacco-related disparities. Policies to reduce SHS exposure include comprehensive smoke-free policies in multi-unit housing, parks and outdoor areas, and in worksites. It is important to protect all population groups and not include exceptions or loopholes in policies that might leave some groups exposed.

## KEY RESOURCES

- Americans for Nonsmokers' Rights - Resources & Tools for Smoke free Multi-Family Housing: <http://www.no-smoke.org/pdf/MUHresources.pdf>
- Americans for Nonsmokers' Rights - Getting Started on Smoke free Multi-Family Housing: <http://www.no-smoke.org/pdf/MUHgettingstarted.pdf>
- CDC: Going Smoke Free Matters Multi-Unit Housing: <https://www.cdc.gov/tobacco/infographics/policy/pdfs/going-smokefree-matters-multiunit-housing-infographic.pdf>
- US Department of Housing and Urban Development (HUD) Guidebook (2017): [https://www.hud.gov/sites/documents/SMOKEFREE\\_GUIDEBK.PDF](https://www.hud.gov/sites/documents/SMOKEFREE_GUIDEBK.PDF)
- HUD Action Guide (2014): <https://www.hud.gov/sites/documents/SFGUIDANCEMANUAL.PDF>
- HUD Public Housing Authority Contacts: [https://www.hud.gov/sites/dfiles/PIH/documents/PHA\\_Contact\\_Report\\_KS.pdf](https://www.hud.gov/sites/dfiles/PIH/documents/PHA_Contact_Report_KS.pdf)
- Tobacco Free Wichita Smoke-Free Housing Initiative: <https://tobaccofreewichita.org/smoke-free-housing-initiative/>
- ChangeLab Solutions Smoke-free Housing: <http://www.changelabsolutions.org/landing-page/secondhand-smoke>
- Public Health Law Center Smoke-free & Tobacco-free Places (Housing, Outdoors, Schools, Workplaces): <http://publichealthlawcenter.org/topics/tobacco-control/smoke-free-tobacco-free-places>
- Public Health Law Center – Tobacco-Free Parks: <http://www.publichealthlawcenter.org/sites/default/files/resources/Tobacco-Free-Parks-Policies-Kansas-2018.pdf>
- Young Lungs at Play: [http://www.kdheks.gov/tobacco/young\\_lungs.htm](http://www.kdheks.gov/tobacco/young_lungs.htm)
- Policy Strategies: A Tobacco Control Guide: [https://cpb-us-w2.wpmucdn.com/sites.wustl.edu/dist/e/1037/files/2004/11/CPHSS\\_TCLC\\_2014\\_PolicyStrategies1-10ik4e1.pdf](https://cpb-us-w2.wpmucdn.com/sites.wustl.edu/dist/e/1037/files/2004/11/CPHSS_TCLC_2014_PolicyStrategies1-10ik4e1.pdf)
- Public Health Law Center - Tobacco Control: <http://www.publichealthlawcenter.org/topics/tobacco-control>
- American Nonsmokers' Rights Foundation – Secondhand Smoke and Children: <https://no-smoke.org/at-risk-people/children>
- Public Health Law Center – Families & Children: <http://www.publichealthlawcenter.org/topics/tobacco-control/smoke-free-tobacco-free-places/families-children>
- Campaign for Tobacco-Free Kids: <https://www.tobaccofreekids.org>
- Campaign for Tobacco-Free Kids – Secondhand Smoke, Kids and Cars: <https://www.tobaccofreekids.org/assets/factsheets/0334.pdf>

- Thirdhand Smoke: <https://no-smoke.org/smokefree-threats/thirdhand-smoke/>
- Guidance for the Clinical Management of Thirdhand Smoke Exposure in the Child Health Care Setting: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5716630/pdf/nihms923008.pdf>

**Secondhand Smoke (1): Increase the number of multi-unit dwellings with smoke-free policies in combination with cessation support.**

**Required Performance Measures:**

1. Proportion of multi-unit housing complexes with 100% smoke-free policies in all units, including balconies and patios where applicable.<sup>iv</sup>
2. Proportion of multi-unit housing complexes with partial smoke-free policies. Partial smoke-free policies include apartment complexes that have smoke-free units but policies do not cover 100% of all units (i.e., only some buildings or sections of buildings have smoke-free units).<sup>v</sup>
3. Proportion of units covered by smoke-free policies in multi-unit housing complexes.<sup>vi</sup>
4. Proportion of multi-unit housing residents covered by smoke-free policies.<sup>vii</sup>
5. Number of multi-unit housing complexes that serve low-income residents with all or some rental units being smoke-free (i.e., Public Housing Authorities, Section 8).

**Secondhand Smoke (2): Increase the number of tobacco-free policies in settings where people gather (e.g., parks, trails, farmers markets, sports arenas and outdoor work areas).**

**Required Performance Measures:**

1. Proportion of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies (provide both the total number of city/county parks/recreation sites and the number of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies).
2. Proportion of parks/recreation sites that currently have smoke-free/tobacco-free policies in areas accessed by disparate populations (e.g., low income). Provide both the total number of parks/recreation sites and the number of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies in areas accessed by disparate populations.

**Secondhand Smoke (3): Increase the number of organizations (childcare providers and those organizations that serve families with young children) that provide education on the dangers of secondhand and thirdhand smoke exposure.**

**Required Performance Measures:**

1. Number of organizations engaged in tobacco prevention and secondhand and thirdhand smoke education serving families with young children.
2. Number of organizations serving families with young children that have implemented a policy, systems or environmental change improving tobacco prevention and reducing secondhand and thirdhand smoke exposure.

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<sup>iv</sup> Provide both the total number of multi-unit housing complexes and the number of multi-unit housing complexes with 100% smoke-free policies in all units.

<sup>v</sup> Provide both the total number of multi-unit housing complexes and the number of multi-unit housing complexes with partial smoke-free policies.

<sup>vi</sup> Provide both the total number of units and the number of units covered by smoke-free policies.

<sup>vii</sup> Provide both the total number of multi-unit housing residents and the number of multi-unit housing residents covered by smoke-free policies.

**PROMOTE QUITTING AMONG ADULTS AND YOUNG PEOPLE**

**NOTE: Promotion of the “Brief Tobacco Intervention” (BTI) web-based training to local providers must be incorporated into the work plan(s) that you choose in the Cessation Goal Area. A brief description of the BTI web-based training can be found in the key resources section.**

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.<sup>22</sup> More than 80% of smokers see a physician every year, and most smokers want and expect their physicians to talk to them about quitting smoking and are receptive to their physicians’ advice.<sup>23</sup> "The Clinical Practice Guideline: Treating Tobacco Use and Dependence" recommends providing tobacco users information on quitting techniques, pharmacotherapies and cessation counseling.<sup>22</sup>

**KEY RESOURCES:**

- Brief Tobacco Intervention Online Training: [www.kstobaccointervention.org](http://www.kstobaccointervention.org)
- The Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update: <https://www.ncbi.nlm.nih.gov/books/NBK63952/>
- Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic (a free interactive multimedia program based on the “Virtual Practicum” model): [www.smokingcessationandpregnancy.org](http://www.smokingcessationandpregnancy.org)
- Dimensions: Tobacco-free Toolkit for Healthcare Providers: <http://www.bhwellness.org/toolkits/Tobacco-Free-Toolkit.pdf>
- A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment: [https://www.cdc.gov/TOBACCO/quit\\_smoking/cessation/pdfs/practical\\_guide.pdf](https://www.cdc.gov/TOBACCO/quit_smoking/cessation/pdfs/practical_guide.pdf)
- Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers: <http://www.smokefreeoregon.com/wp-content/uploads/2011/01/LEG-Community-Health-Report-Inside-Final-10-11-13.pdf>
- Smoking Cessation Leadership Center Toolkits: <https://smokingcessationleadership.ucsf.edu/behavioral-health/resources/toolkits>

**Cessation (1): Promote adoption of the *Kansas Tobacco Guideline for Behavioral Health Care* by behavioral health care facilities.**

**Required Performance Measures:**

1. Number of facilities that adopt the *Kansas Tobacco Guideline for Behavioral Health Care*.
2. Number of facilities that establish a new policy, systems or environment change that includes the KDHE “Brief Tobacco Intervention” web-based provider training.
3. Number of behavioral health providers in target locations who complete the KDHE “Brief Tobacco Intervention” web-based provider training.
4. Number of individuals referred to the Kansas Tobacco Quitline phone or web-based service by a health care professional.

**Cessation (2): Establish tobacco dependence screening, referral and treatment systems within clinics.**

**Required Performance Measures:**

1. Number of clinics that establish a systems change to adopt or improve tobacco dependence treatment including screening, referring and providing brief tobacco dependence treatment.
2. Number of clinics that serve the medically underserved patient population (e.g., Community Care Network of Kansas clinics) that establish a systems change to adopt or improve

- tobacco dependence treatment including screening, referring and providing brief tobacco dependence treatment.
3. Number of clinic providers who complete the KDHE “Brief Tobacco Intervention” web-based provider training.

**Cessation (3): Establish tobacco cessation screening, referral and counseling systems targeting healthcare providers serving women during the perinatal period. Examples of interventions include: increasing KanQuit online enrollment using a "warm handoff" model in WIC clinics; implementation of an evidence-based smoking cessation program (i.e., SOPHE Smoking Cessation Reduction in Pregnancy Treatment - SCRIPT®, Baby and Me Tobacco Free - BMTF) or establishing a Brief Tobacco Intervention training policy requirement.**

**Required Performance Measures:**

1. Number of health care provider organizations that establish a systems change to adopt or improve practices for tobacco dependence treatment during pregnancy including screening, referring and providing brief tobacco dependence treatment.
2. Number of health care provider organizations that establish a new policy, systems or environment change that includes the KDHE “Brief Tobacco Intervention” web-based provider training.
3. Number of health care providers in target locations who complete the KDHE “Brief Tobacco Intervention” web-based provider training.
4. Number of women who are currently pregnant, planning pregnancy or currently breastfeeding who enroll in the Kansas Tobacco Quitline.
5. If SCRIPT or BMTF selected: Number of staff who successfully complete SCRIPT® or BMTF program training.
6. If SCRIPT or BMTF selected: Number of women who participate in SCRIPT® or BMTF program.
7. If SCRIPT or BMTF selected: Number of women who abstain from smoking throughout pregnancy.

**INCREASE PHYSICAL ACTIVITY, ACCESS TO HEALTHY FOODS, AND COMMUNITY RESILIENCY (PAN)**

Physical inactivity and poor nutrition are two of the three main risk factors leading to multiple chronic diseases, including heart disease, stroke, and some cancers. Whether or not people engage in physical activity and healthy diets is the result of many factors, including culture, socioeconomic status, and the built environment. Disparities in health outcomes among different populations are exacerbated by policy and environmental barriers to healthy food and physical activity access. Increasing access to physical activity opportunities and healthy food, and thereby decreasing the prevalence of chronic diseases, requires a coordinated and comprehensive approach that engages underserved populations in identifying needs and solutions, works with and through diverse sectors and partners in the community, and implements policies, systems and environments supportive of healthy food and physical activity access, especially for underserved populations.

**KEY NUTRITION RESOURCES:**

- ChangeLab Solutions: <http://www.changelabsolutions.org/>
  - The Community Guide: <https://www.thecommunityguide.org/>
  - Dietary Guidelines 2015-2020 Eighth Edition: <http://health.gov/dietaryguidelines/2015/guidelines/>
  - The Food Trust: <http://thefoodtrust.org/>
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- Healthy Food Policy Project: <http://healthyfoodpolicyproject.org/>
- Johns Hopkins Food Policy Networks, resources: <http://www.foodpolicynetworks.org/food-policy-resources/>
- Public Health Law Center - Kansas Resources: <http://publichealthlawcenter.org/topics/special-collections/kansas-resources>

**Nutrition (1): Support healthy food systems and improved access to foods in community settings by forming a food policy council, or advancing one or more food policy council priorities through policy, systems, and environmental changes. Communities selecting Nutrition (1) must enter their food policy council information into the [Johns Hopkins Food Policy Networks directory](#).**

**Required Performance Measures:**

1. Number of city/town jurisdictions covered by the food policy council.
2. Sectors of organizations represented on food policy council (i.e., farmers/gardeners, processors, transporters/distributors, grocers/wholesalers, restaurateurs/chefs, food banks/pantries, consumers, waste management/composting, public health officers, farm and food worker advocates, elected officials/policymakers, other government representatives, and other community members).
3. Number of organizations represented on food policy council.
4. Type of food policy council priorities that advance policy, systems, and environmental change to support healthy food systems and food access (i.e., transportation infrastructure to access healthy foods, food directories, healthy food retail conversions, permit systems for sidewalk vending, mobile markets accepting nutrition benefits (SNAP-EBT, WIC), community gardens, farm-to-table, farmers markets/farm stands, regional food hubs, and other).
5. Number of food policy council priorities that advance policy, systems, and environmental change to support healthy food systems and food access.
6. Number of adults impacted by the food policy council priorities that advance policy, systems, and environmental change to support healthy food system and food access.

**Nutrition (2): Support healthy food systems and improved access to foods in community settings by establishing new farmers markets, expanding farmers markets, or promoting use of Senior Farmers Market Nutrition Program (SFMNP), Farmers Market Nutrition Program (FMNP), Supplemental Nutrition Assistance Program-Electronic Benefits Transfer (SNAP-EBT), and Double-Up Food Bucks (DUFEB) at farmers markets.**

**Required Performance Measures:**

1. Number of farmers markets serving the community who are registered with USDA and/or From the Land of Kansas.
  2. Number of farmers markets serving the community that accept federal, state, or local nutrition assistance benefits programs (i.e., SFMNP, FMNP, SNAP, DUFEB) as tracked in the USDA and From the Land of Kansas directories.
  3. Number of farmers markets serving the community that offer match dollars for nutrition assistance benefits programs (i.e., SFMNP, FMNP, SNAP, DUFEB).
  4. Number of farmers markets serving the community that implement new infrastructure improvements, improved public transportation options to market, or permanent promotional materials.
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5. If workplan includes expanding existing markets, grantee **must** propose 1 to 3 additional performance measures that demonstrate impact of expansion (e.g., number of vendors added to a market, increases in foot traffic, SNAP-EBT revenue, number of vendors certified to accept SFMNP, FMNP, SNAP-EBT, or DUFB).

#### KEY PHYSICAL ACTIVITY RESOURCES:

- The Case for Healthy Places: Improving Health Outcomes through Placemaking: <https://www.pps.org/wp-content/uploads/2016/12/Healthy-Places-PPS.pdf>
- ChangeLab Solutions: <http://www.changelabsolutions.org/>
- The Community Guide: <https://www.thecommunityguide.org/>
- Complete Streets and Bicycle and Pedestrian Plans Fact Sheets: <https://www.saferoutespartnership.org/resources/fact-sheet-report/complete-streets-and-bicycle-and-pedestrian-plans>
- Physical Activity Guidelines for Americans, second edition: <https://health.gov/paguidelines/second-edition/>
- Public Health Law Center - Kansas Resources: <http://publichealthlawcenter.org/topics/special-collections/kansas-resources>
- Smart Growth America: <http://www.smartgrowthamerica.org/>
- Surgeon General's Call to Action to Promote Walking and Walkable Communities: <https://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/index.html>

**Physical Activity (1): Promote physical activity and active transportation in community settings by forming or strengthening bicycle & pedestrian advisory committee(s) to coordinate local community design policy efforts and awareness activities.**

##### Required Performance Measures:

1. Number of city/town jurisdictions covered by bicycle & pedestrian advisory committee(s).
2. Types of diverse representation on bicycle & pedestrian advisory committee(s) (e.g., men, women, minorities, recreational and commuter cyclists, senior citizens, students, business owners, environmental and social justice advocates, and other community members).
3. Sectors of organizations represented on bicycle & pedestrian advisory committee(s) (e.g., nonprofit, for-profit, school districts, universities/colleges, public health officers, elected officials/policymakers, other government representatives, and other community members).
4. Number of organizations represented on bicycle & pedestrian advisory committee(s).
5. Number of policies implemented that support environmental changes to enhance places for biking and/or walking.
6. Number of adults impacted by policies implemented that support environmental changes to enhance places for biking and/or walking.

**Physical Activity (2): Promote physical activity and active transportation in community settings by planning and/or implementing policy, systems, and environmental changes to increase public access to services and resources through destination-based routes.**

##### Required Performance Measures:

1. Type of policy, systems, or environmental changes(s) planned and/or implemented to increase active transportation and access to services and resources, (e.g., design standards, Complete Streets, Complete Parks, joint/shared use agreements, Safe Routes to School, bike/pedestrian transportation plans, master trail plans, or other)

2. Number of policy, systems, or environmental change(s) planned and/or implemented to increase active transportation and access to services and resources.
3. For community-wide policy, systems, or environmental changes: Number of residents in jurisdiction(s) with community-wide policy, systems, or environmental change(s) that are planned and/or implemented to increase active transportation and access to services and resources.
4. For site-specific policy, systems, or environmental changes: Number of residents utilizing sites that plan and/or implement site-specific policy, systems, or environmental changes to increase active transportation and access to services and resources.

**Physical Activity (3): Promote physical activity and active transportation in community settings by implementing a creative placemaking/repurposing infrastructure project to encourage physical activity and economic resilience.**

**Required Performance Measures:**

1. Type of creative placemaking or repurposing infrastructure project(s) developed/implemented (*communities enter their own answers*).
2. Number of creative placemaking or repurposing infrastructure project(s) developed/implemented.
3. Type of community partners engaged in the development and implementation of creative placemaking project(s) and/or repurposing infrastructure (i.e., nonprofit, for-profit, school districts, universities/colleges, public health officers, elected officials/policy makers, other government representatives, and other community members).
4. Number of community partners engaged in the development and implementation of creative placemaking project(s) and/or repurposing infrastructure.

**INCREASE THE ABILITY OF THOSE WITH CHRONIC DISEASE TO MANAGE THEIR CONDITION(S) (CDSME)**

Chronic Disease Self-Management Education programs are evidence-based curricula developed by Stanford University and licensed by the Self-Management Resource Center. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshops are recommended for anyone living with one or more chronic conditions, family or friends of those living with a chronic condition as well as caregivers. These interactive workshops provide participants with techniques to deal with symptoms such as pain, fatigue and depression associated with chronic conditions. Participants also learn and practice problem-solving and action planning.

**CDSME (1): Promote and coordinate the expansion of CDSME programming opportunities and their reach.**

**Required Performance Measures:**

1. Number of organizations coordinating and implementing one or more CDSME workshop(s) consistently (i.e., one or more workshop per year). CDSME programs include the Chronic Disease Self-Management Program.
2. Number of potential delivery partners.
3. Number of community organizations referring to workshops (include organization names).
4. Number of providers referring to workshops through a trackable referral system (a trackable referral system includes systems, such as Electronic Health Records that allows providers to

track when referrals are sent and if referred patients attend and/or complete the CDSME program).

**KEY RESOURCES:**

- Self-Management Resource Center: <https://www.selfmanagementresource.com/>
- Kansas Department of Health and Environment, Tools for Better Health: [www.ToolsForBetterHealthKS.org](http://www.ToolsForBetterHealthKS.org)
- Kansas Self-Management Education: [www.SelfManageKS.org](http://www.SelfManageKS.org)

**Note:** Media material must include the KDHE logo to comply with the Stanford licensing guidelines. All media material must be sent to and approved by KDHE before distributing.

**Recommended Action Steps:** Identify a local CDSME program coordinator. Coordinator will:

1. Provide TA to local leaders and organizations while they coordinate and implement workshops.
2. Assist in marketing/promotion efforts (e.g., distribute educational materials to recruit participants, leverage earned media to recruit delivery partner organizations and participants)
3. Ensure that CDSME leaders send workshop forms to the Kansas Foundation for Medical Care via mail or secure email.
4. Engage **one or more organizations** to commit to being delivery-system partners who will work to implement and coordinate CDSME workshops one or more times a year, and is willing to have a CDSME Champion within that organization to coordinate CDSME efforts.

Work with KDHE CDSME Coordinator to identify and recruit **one or more health care providers** as referral partners.

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## Application Instructions

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### **Incomplete applications will not be considered.**

Please direct any questions to your regional Community Health Specialist. Applicants are encouraged to have assigned Community Health Specialist review application at least 48 hours prior to submission to ensure application is complete.

The application will be completed using the Kansas Grant Management System (KGMS). First time applicants may contact Karen Kelley, Kansas Grant Management System Manager, at [Karen.Kelley@ks.gov](mailto:Karen.Kelley@ks.gov) for information about using KGMS.

After obtaining a KGMS account, applicants must access KGMS, select the Chronic Disease Risk Reduction SFY2020 application, fill in requested information and attach the supplemental application forms explained below.

Refer to the appropriate CDRR Scoring Guidance while writing your application. Guidance documents can be found on the KGMS Chronic Disease Risk Reduction web page.

### **Application Forms (completed separately and uploaded into the Kansas Grant Management System)**

Implementation applicants must complete the following forms: **Coalition Membership** and **Salary Worksheet**.

#### **Coalition Membership Form**

- a. A functional coalition is a requisite for successful community-based chronic disease prevention.
- b. Sectors of community support are provided as a guideline for composition of an optimal community coalition.
- c. Applicants should include all sectors with direct relevance to selected goals and outcomes. Each sector may have multiple participants.

#### **Salary Worksheet:**

- a. List the employee name and title for each proposed staff member. Complete salary spreadsheet and enter information in blank fields indicating number of hours worked per week, percentage of time spent on grant, salary and allocation of time allocated to tobacco use prevention, physical activity and nutrition, and CDSME. Fields will automatically populate based on information entered.
- b. Grant funds for staffing may be used for grant coordination and activity implementation through local health educators/outreach workers.
- c. No more than 10 percent of administrators' salaries may be funded by CDRR.

**Planning Applicants Only:** Planning applicants need to complete the following documents that can be found attached in the Kansas Grant Management System: **CDRR Planning Phase Form** and **Salary Worksheet**.

#### **Planning Phase Form:**

- a. Complete table listing any connections available that are available to build a coalition.
  - b. Identify existing community priorities and the groups that are working on those priorities for tobacco control, physical activity and nutrition, and CDSME if applicable.
  - c. Identify types of partnerships that are beneficial to meeting your goals.
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The salary worksheet is described above.

**For both planning and implementation applicants who are not local health departments:** Obtain a letter from the local county health department designating applicant agency and upload it with the other required forms.

**Implementation Applicants are required to complete the Administration section in KGMS. Every field in the Administration form in KGMS is indicated below:**

### Administration

- a. Fields to be completed:
  - i. Counties to be served
    - Select the counties to be served in the proposed workplans.
  - ii. Community Profile and Statement of Need
    - Provide a clear and specific description of the community that includes data from existing sources on community demographics and the prevalence of behaviors and/or chronic diseases.
    - Grantees are required to utilize existing data sources in planning their application. The community profile and statement of need should describe how information from the existing data sources justify their selected workplans and target populations. Below are a list of recommended data sources that should be used in addition to other community level data that may be available (e.g., Kansas Tobacco Quitline reports, food policy council assessment, existing community health assessment, etc.).
      - Recommended data sources:
        - Kansas Behavioral Risk Factor Surveillance System: This data sources provides prevalence for chronic diseases and their associated risk factors in the overall population and in target population subgroups. Data are available at the state, regional, and county level.
          - Local-level reports: [http://www.kdheks.gov/brfss/HRSReports/local\\_hrs\\_reports\\_index.htm](http://www.kdheks.gov/brfss/HRSReports/local_hrs_reports_index.htm)
          - Local-level data: <http://www.kdheks.gov/brfss/BRFSS2015/index.html>
          - State-level data: <http://www.kdheks.gov/brfss/>
        - Kansas Information for Communities: This website provides access to information about population demographics and vital statistics.
          - <http://kic.kdheks.gov/>
        - American Fact Finder: This website provides access to information about population demographics and socioeconomic characteristics. One particularly useful link on this page is General Economic Characteristics. This provides information about poverty and housing characteristics and is available at the community level.

- <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>
  - Kansas Annual Summary of Vital Statistics: This report provides information about smoking during pregnancy at the county level in addition to other relevant vital statistics information (e.g., births, deaths).
  - Link to the 2017 report:  
[http://www.kdheks.gov/phi/as/2017/Annual\\_Summary\\_2017.pdf](http://www.kdheks.gov/phi/as/2017/Annual_Summary_2017.pdf)
  - Kansas Health Matters: This is a clearinghouse website that contains information from a variety of sources, including some selected information from the Kansas Behavioral Risk Factor Surveillance System and the KDHE Office of Vital Statistics.
    - <http://www.kansashealthmatters.org/>
  - Provide a clear and full explanation of how the funds will benefit the community through the selected workplans.
- iii. Community Capacity
  - Describe plan for staff, partnership collaboration, resources, and necessary training and tools needed to support the workplans.
- iv. Health Equity
  - Provide details on community plan for engaging and impacting populations experiencing preventable health inequities and how your community will work to advance health equity community-wide.

**Interventions to Improve Public Health – NOTE: To be funded for CDRR, at least one tobacco workplan under Prevention or Secondhand Smoke must be selected. Cessation, Physical Activity and Nutrition, and CDSME workplans are optional. Grantees are encouraged to select no more than 5 workplans.**

**Applicants should opt out of the workplans that are not selected for implementation.**

- a. Required Fields for each workplan selected:
  - i. Multi-year SMART Objective
    - Multi-year Objective must be SMART - Specific, Measurable, Achievable, Realistic and Time-bound.
    - The multi-year objective will lead to progress on required performance measures and be clearly tied to the workplan.
    - SMART format: "By [date], increase or decrease [y] to [x]."
  - ii. Annual SMART Objective
    - Annual Objective must be SMART - Specific, Measurable, Achievable, Realistic, and Time-bound.
    - The annual objective should ultimately lead to progress on multi-year objective and required performance measures.
  - iii. Target Population
    - Describe and quantify the group of people this activity will help. Applicants should be using existing data sources. Please see the list of recommended sources above.

- iv. Target Organization
  - List organizations this activity will impact. If you plan to help students, then the organization would be the schools you plan to work with. If you want to work with employees, then the organization would be their employer.
- v. Action steps (5-10 Steps)
  - Action steps are purposeful, logical and will lead to significant progress on objectives.
- vi. Communications
  - Describe specific instances of proposed earned media, social media, public relations efforts and paid media activities (if applicable).
- vii. Performance Measures and Data Sources
  - Required performance measures for each workplan are auto-filled in KGMS. Include data sources that will be used to address the required performance measures.
  - Where applicable, applicants are encouraged to include a limited number of additional quantitative process measures to evaluate progress towards reaching the annual objective and required performance measures. Focus on 1 to 3 important measures. Consider including a measure that addresses how underserved populations are engaged or reached.
- viii. Evidence and Long-Term Impact
  - Describe how workplan is evidence-based, linked to sustainable policy, systems or environmental changes, shows synergy with other work in the community and appears very likely to produce significant long-term positive impact.

### Budget:

- a. General Budget: All applicants must complete a budget.
  - i. Complete the budget line items within the grant management system providing the necessary financial information in the Salary/Personnel, Benefits, Supplies, Travel, Subcontractors, and Paid Media categories. Provide a complete description of staff responsibilities and justification for expenditures.

<sup>1</sup>Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. . Available at: [https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND\\_TL221.pdf](https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf). Accessed October 30, 2018.

<sup>2</sup> Health Care Expenditures by State of Residence (in millions). Kaiser Family Foundation, Available at <https://www.kff.org/other/state-indicator/health-care-expenditures-by-state-of-residence-in-millions/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22kansas%22:%7B%7D%7D%7D&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed January 11, 2019.

<sup>3</sup> Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Accessed November 1, 2016.

<sup>4</sup> Social Determinants. Healthy People. Available at: <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants>. Accessed October 30, 2018.

<sup>5</sup> National Partnership for Action to End Health Disparities. National Stakeholder Strategy for Achieving Health Equity. Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health, [April 2011] [https://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_05\\_Section1.pdf](https://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf)

<sup>6</sup> Campaign for Tobacco-Free Kids. [http://www.tobaccofreekids.org/facts\\_issues/toll\\_us/kansas](http://www.tobaccofreekids.org/facts_issues/toll_us/kansas). Accessed November 1, 2016.

<sup>7</sup> 2013 Kansas Behavioral Risk Factor Surveillance System. Bureau of Health Promotion, Kansas Department of Health and Environment.

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- <sup>8</sup> 2014 Kansas Behavioral Risk Factor Surveillance System. Bureau of Health Promotion, Kansas Department of Health and Environment.
- <sup>9</sup> 2017 Kansas Behavioral Risk Factor Surveillance System. Bureau of Health Promotion, Kansas Department of Health and Environment.
- <sup>10</sup> 2017 Kansas Youth Risk Behavior Survey. Kansas State Department of Education.
- <sup>11</sup> U.S. Department of Health and Human Services. Public Health Service; National Institutes of Health; National Heart, Lung and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; 1998.
- <sup>12</sup> U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans*.
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